New Jersey Office of the Attorney General
Division of Consumer Affairs
Board of Pharmacy
124 Halsey Street, 6th Floor, Newark, NJ 07102
(973) 504-6450

Joint Application to Conduct a Centralized Prescription Handling Pharmacy Service

Pharmacies that plan to engage in central prescription handling in accordance with N.J.A.C. 13:39-4.18 must submit this application to the Board of Pharmacy.

All of the pharmacies involved in the shared central handling must complete and jointly file this application. It must be filled in completely, sworn to and mailed to the Board of Pharmacy.

Please use a typewriter or print with ink.

Pursuant to N.J.A.C. 13:39-4.18, the following pharmacies and/or corporations hereby make application for approval to conduct centralized prescription handling and certify to the correctness of the following information:

1. _____
2. _____
3. _____
4. _____

☐ **Check box and attach a list if there are more than four pharmacies involved.**

If participating pharmacies have different ownership - Complete Attachment "A" for each pharmacy and/or corporation that will be participating in the centralized prescription handling. (Make as many copies as you need.) Corporations with more than one pharmacy participating should submit documentation (a spreadsheet is preferred) that contains the following information: the name, address, telephone number, and the license numbers (state and D.E.A.) of each participating pharmacy, as well as the function(s) to be performed in the centralized prescription handling process.

If all participating pharmacies have a common owner - Complete one copy of Attachment "A" and submit documentation (a spreadsheet is preferred) that contains the following information: the name, address, telephone number, and the license numbers (state and D.E.A.) of each participating pharmacy, as well as the function(s) to be performed in the centralized prescription handling process.

You will be notified by mail when your application has been approved by the Board.

Attachment "A"

Application to Conduct a Centralized Prescription Handling Pharmacy Service

Check all functions in the centralized prescription handling process that this pharmacy will perform:

☐ **Intake** ☐ **Central Processing** ☐ **Central Fill** ☐ **Dispensing**

1. If application is being made for a noncorporate single pharmacy, complete the information below:

   (a) Name under which pharmacy is to be operated:_____

   (b) Street address of pharmacy: _____

   (c) City: _____ State: _____ ZIP Code: _____

   (d) Telephone number: _____
   (include area code)

   (e) Home State Pharmacy License Number: _____

   (f) Federal Controlled Substance (D.E.A.) Registration Number:_____

   (g) If application is **not** being made for a corporation, list below the names and addresses of individuals, partners, trustees, receivers, executors or other persons in whom ownership will be vested:

   _____
   Full name of owner | Home address | Percentage of ownership | R.Ph. License Number

   _____
   Full name of owner | Home address | Percentage of ownership | R.Ph. License Number

   _____
   Full name of owner | Home address | Percentage of ownership | R.Ph. License Number

2. If application is being made for a corporation, complete the information requested below:

   (a) _____
   Name and Address of Registered Agent of Corporation

   (b) Date of incorporation: _____State of incorporation: _____

   (c) Is the corporation's stock: ☐ publicly traded; or ☐ not publicly traded?

   (d) The names and addresses of all officers and owners of 10 % or more of stock. (Note: an affidavit must be submitted to the Board within 30 days after any change of registered agents, corporate officers or any change of stock ownership involving 10% or more of the outstanding stock.):

Title	Name	Home Address	Percent of Stock	R.Ph. License Number
President				
Vice President				
Secretary				
Treasurer				

Other				
Other				
Other				
Other				

3. Are there any pending indictments of any nature or any alleged violations of the laws governing the practice of pharmacy, dispensing narcotics, alcohol, hypnotic or other regulated drugs against any of the individuals listed in items one or two of this application or have any of them been convicted of any crime within the past 10 years? ☐ Yes ☐ No

   If "Yes," give details: _____

   _____

   _____

4. The affidavit below must be completed by the owner, or a partner, as listed on this application or, if the pharmacy is owned by a corporation, by a principal officer.

Affidavit "A" must be sworn to before a notary public or other authorized officer.

I do solemnly swear and affirm that the answers and statements made in this form are true and correct to the best of my knowledge and belief. I understand that I am responsible for ensuring that each pharmacist-in-charge of each pharmacy participating in the centralized prescription handling process has been notified and has acknowledged that he/she is responsible for complying with *N.J.A.C.* 13:39-4.18, and for conducting and managing the pharmacy so as to be in compliance with all applicable state and federal laws.

Affidavit "A"

_____

Name of Pharmacy (If a corporation, give exact legal title)

_____

Signature (circle title below)

Owner, Partner, Trustee, Lessee, Executor, President, Vice President, Secretary, Treasurer, Officer, Director

Subscribed and sworn to me this _____

day of _____ A.D. _____

_____

Notary's signature

_____

My commission expires